Dermatology Medical History

Patient:____ **Date**______________________

Occupation:____

Race:_____________ **Ethnicity:**_____________ **Hobbies:**_____________________________

Please place a check next to any of the following Medical Conditions that apply to you:

Medical Condition	✔	Medical Condition	✔	Medical Condition	✔
Anxiety		Depression		Hypothyroid	
Arthritis		Diabetes		Leukemia	
Asthma		End Stage Renal Disease		Lung Cancer	
Atrial Fibrilation		GERD/Acid Reflux		Lymphoma	
Bone Marrow Transplant		Hearing Loss		Prostate Cancer	
BPH		Hepatitis		Radiation Treatment	
Breast Cancer		Hypertension		Seizures	
Colon Cancer		HIV/AIDS		Stroke	
COPD		High Cholesterol			
Coronary Artery Disease		Hyperthyroid			

Please List any additional medical conditions not listed above:

Please place a check mark next to the surgeries you have had along with the approximate date:

SURGERY	✔	DATE	SURGERY	✔	DATE
Appendix			Kidney Transplant		
Bladder Surgery			Nephrectomy (kidney removal)		
Breast Biopsy			Hepatectomy (liver removal)		
Breast Lumpectomy*			Liver Transplant		
Mastectomy*			Liver Shunt		
Colon Surgeries*			Ovarian Surgeries*		
Gallbladder			Pancreatectomy (pancreas removal)		
Biological Heart Valve Replacement			Prostate Surgeries*		
Coronary Artery Bypass			Rectal Surgeries*		
Heart Transplant			Basal Cell Carcinoma		
Mechanical Heart Valve Replacement			Squamous Cell Carcinoma		
Heart(coronary artery) Angioplasty			Spleen Removal		
Joint Replacement (which joints)*			Testical Removal		
Kidney Biopsy			Hysterectomy*		
Kidney Stone Removal					

Please list any additional surgeries not listed above:

Please check any of the following skin condition you have or have had in the past:

Skin Condition	✔	Skin Condition	✔
Acne		Flaking or Itchy Scalp	
Actinic Keratosis (pre-cancerous)		Hay Fever/Allergies	
Asthma		Melanoma	
Basal Cell Carcinoma		Poison Ivy	
Blistering Sunburns		Atypical(precancerous) Moles	
Dry Skin		Psoriasis	
Eczema		Squamous Cell Carcinoma	

Do You Wear Sunscreen?________If yes what SPF?____________
Do You Tan in a Tanning Salon?__________
Do You have any family history of Melanoma_______If yes please list which relative(s)____

Medications and Allergies:

List all medications that you are currently taking:
(Please include prescriptions, over-the-counter medications, vitamins and herbals)

____________________ ____________________ ____________________ ____________________
____________________ ____________________ ____________________ ____________________
____________________ ____________________ ____________________ ____________________

Are you allergic to any medications? **Yes No**

If yes, please list:____

Do you drink alcohol? ☐Yes ☐No If yes, how many per day?____________________

Do you smoke? ☐Yes ☐ No If yes, How many packs per day?_______________

Do you use IV drugs? ☐ Yes ☐No If yes, what and how much?__________________

Do you have any family history of Skin Cancer? _______If yes please list which relative and type of Skin Cancer if Known:____

Do you bleed easily? ☐Yes ☐No

(Women) Are you pregnant ☐Yes ☐No

____ ____________________________________

Signed by patient Date Reviewed by Date